Aquidneck Dental, Inc. 21 King Charles Drive Portsmouth, RI 02871 401.683.5990

Patient Medical History

Physician's Name_____ Date of last Medical Check Up___/__/__

Physician's Address_____ Physician's Phone #_(___)_____

1. Are you under medical treatment now? ☐ Yes ☐ No
   If yes, for what?_____
2. Do you currently have any medications prescribed for you? ☐ Yes ☐ No
   If yes, please list all medications, vitamins and supplements_____
   _____
3. Have you ever had any major operations? ☐ Yes ☐ No
   If yes, what_____ When?_____
4. Have you had any wounds that healed slowly? ☐ Yes ☐ No
5. Have you had any adverse reactions to any medications, foods, or materials? ☐ Yes ☐ No
   If yes, please list all items_____
6. Are you currently in good health? ☐ Yes ☐ No
7. For Women: Are you, or is there a possibility you may currently be pregnant? ☐ Yes ☐ No
8. Are you currently taking any medications to treat Osteoporosis? ☐ Yes How long?_____ ☐ No
9. Do you use any tobacco products? ☐ Yes ☐ No

Has your physician ever informed you that you have or had:

Allergies/Hay Fever	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Latex Allergy	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Metal Allergies	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No	Mental Disorders	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Nervous Disorders	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No
Cancer/Tumors	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No
Clotting Disorder	☐ Yes ☐ No	Pregnancy	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No
Dizziness/Fainting	☐ Yes ☐ No	Respiratory Problems	☐ Yes ☐ No
Epilepsy/Seizures	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Excessive Bleeding	☐ Yes ☐ No	Sinus Problems	☐ Yes ☐ No
Glaucoma	☐ Yes ☐ No	Stomach Problems	☐ Yes ☐ No
Head Injuries	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Heart Disease	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Heart Surgery	☐ Yes ☐ No	TMD	☐ Yes ☐ No
High/Low Blood Pressure	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Heart Murmur/ MVP	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Hepatitis	☐ Yes ☐ No	Other ***	☐ Yes ☐ No
HIV/AIDS	☐ Yes ☐ No	***Please list_____	
Jaundice/Liver Disease	☐ Yes ☐ No	_____	

Dental History

What is your main dental concern?_____

When was your last Dental Exam?_____ Last X-rays?_____ Last Cleaning?_____

Have you had Orthodontic Treatment? ☐ Yes ☐ No
Have you had Periodontal Treatment? ☐ Yes ☐ No
Do you clench or grind your teeth? ☐ Yes ☐ No.....Daytime?____Nighttime?_____
Do you have ear pain, sore muscles? ☐ Yes ☐ No.....Do you awaken with headaches?_____
Are you apprehensive about seeing a dentist? ☐ Yes ☐ No.....Why?_____

Emergency Information

Name of nearest relative not living with you_____ Phone#_(___)_____

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